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Epidemiology characteristics of patients with heart failure with emphasis on HFpEF-data from Croatian and European HF registries

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Introduction: Heart failure (HF) is disease with high morbidity and mortality, despite advanced treatment. ESC, HFA and Croatian HF Society try to improve prognosis and quality of life for HF patients creating projects and registries. The HF Surveys and registries have been developed with the intention to analyzed HF population and to improve diagnosis, treatment and prognosis according to ESC guidelines.[1] The aim of this presentation is to analyze epidemiology characteristics of a growing population with HF diagnosis with special attention on HFpEF type, according to data from Croatian and European HF Registries.

Methods: The data of EuroHeart Failure Survey (EHFS), ESC-HF Pilot Survey (ESC-HF Pilot), ESC HF Long-term Registry (ESC-HF-LT-R), Heart Failure III Registry (HF-III-R) and Croatian HF Registry (CRO-HF-R), were analyzed.

Results: The results from EHFS suggested that de novo AHF was diagnosed in 37% (42% ACS) and HFpEF in 34% (45% women and 22% men). Important triggers were arrhythmias and ACS. The results from ESC-HF Pilot showed that ischemic etiology was reported in about half of the patients, with acute HF (AHF) presentation. All-cause mortality in patients with HFpEF was lower than in HFrEF. ESC-HF-LT-Registry showed that the presence of diabetes and COPD markedly increased the risk of 1-year adverse events. HFpEF had 33.4% patients. More than 50% AHF patients had ischemic etiology; frequent comorbidities are diabetes, COPD, hypertension and atrial fibrillation. ESC HF III Registry showed that 58% patients had HFrEF, 17% HFmEF, 25% HFpEF. In the hospital died 5.1% patients (HFrEF 5.2%, HFmEF 4.8%, HFpEF 3.4%). Rehospitalization of AHF patients: 44% HFrEF, 42% HFmrEF, 36% HFpEF. HFrEF and HFmrEF are mostly results of primary myocardial injury. HFpEF appear to be a different syndrome, secondary to comorbidity-driven systemic inflammation and progressive fibrosis and cardiomyocyte changes. Data from the CRO-HF Registry indicate that HF presentation might differ between gender. HFpEF/HFmEF was recorded in 37.8% and HFrEF in 62.2% of patients. Distribution of HFrEF: M 70.7%, F 50.7%, and HFpEF/HFmEF: M 29.3%, F 49.3%. Females have frequently higher values of ALT, cholesterol, triglycerides, uric acid and preserved LVEF, while males have lower values of hemoglobin and LVEF. Hypertension is important "trigger" of HF in females and ACS in males. HF treatment should be adapted to clinical presentations of HF according to gender.

Conclusions: Registries are important source of information about characteristics, diagnosis, treatment and prognosis of patients, with our goal to improve survival and quality of life HF patients.

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LITERATURE

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